The California Department of State Hospitals

# COVID-19 Transmission-Based Precautions and Testing

August 2020

Update approved by the DSH Executive Team on August 27, 2021

# Contents

The guidelines and protocols included in this document were developed in partnership between DSH and the California Department of Public Health, Healthcare Associated Infections (HAI) Program to provide guidelines for COVID-19 transmission-based precautions and testing. These guidelines represent current best practices and may require regular updates. These are the minimum requirements. Each hospital develops local operating procedures to support these protocols based on their resources, staffing and physical plant layout. Local Public Health Department collaboration is highly encouraged to further support these State protocols.

## Definitions

**Admission Observation Unit (AOU):** Houses patients arriving to the hospital for admission and in certain circumstances patients arriving from receiving outside care/services. Patients are isolated and tested for 10 days. CDC defines this prevention measure as Routine Intake Quarantine.

**Fully Vaccinated:** Individuals two weeks or more after they have received the second dose in a 2-dose series (Pfizer-BioNTech or Moderna), or two weeks or more after they have received a single-dose vaccine (Johnson and Johnson [J&J]/Janssen). For staff who did not receive vaccination via DSH, proof of vaccination must be provided before they are considered fully vaccinated.

**Healthcare Personnel (HCP):** All paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

**Not Fully Vaccinated:** A person who has received at least one dose of COVID-19 vaccine but does not meet the definition of fully vaccinated.

**Isolation Area:** Separates patients who refuse testing from those that are under serial testing. Isolation areas may be in a home unit or any specified locations within each hospital.

**Isolation Unit:** Separates confirmed COVID-19 (+) patients from people who are not infected.

**Persons Under Investigation (PUI) Unit/Rooms:** Separates patients in individual rooms that have symptoms consistent with COVID-19 disease who are potentially exposed who are not confirmed to be infected.

**Personal Protective Equipment (PPE):** Refers to protective clothing, helmets, gloves, face shields, goggles, surgical masks and/or respirators or other equipment designed to protect the wearer from injury or the spread of infection or illness, and chemical and biological hazards.

**Quarantine Unit:** Houses asymptomatic patients that have been exposed to a patient or an HCP (either assigned to the unit or visiting) that is suspected (PUI) or confirmed with COVID-19 infection. A Quarantine Unit is activated when patients are exposed to a confirmed or suspected COVID-19 patient or HCP.

**Transmission-Based Precautions:** The second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Contact Precautions: Precautions for patients with known or suspected infections that represent an increased risk for contact transmission. Examples include COVID-19, MRSA, VRE, diarrheal illnesses, open wounds and RSV.

**Unvaccinated:** A person who has not received any doses of COVID-19 vaccine or whose status is unknown.

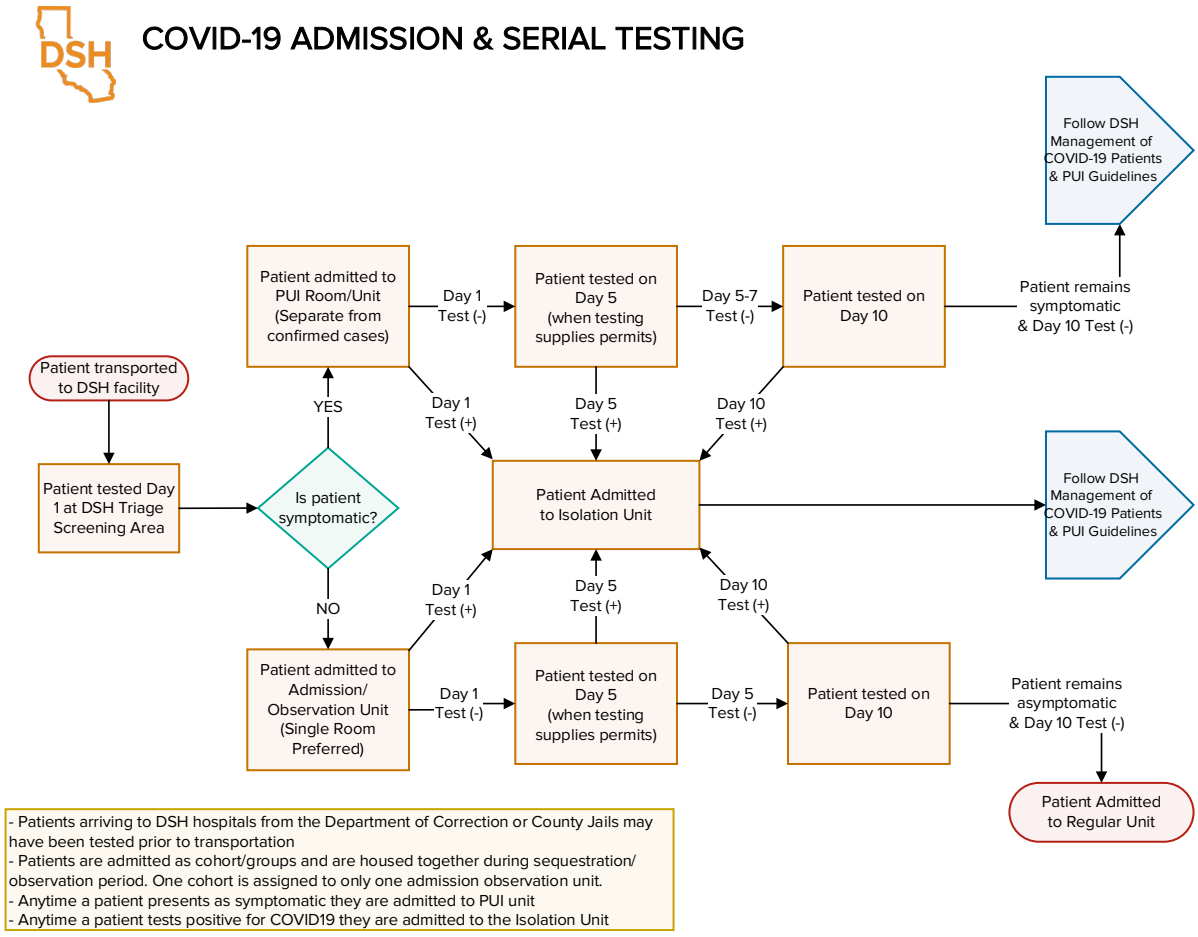
# I. Admission Testing

Unvaccinated patients that arrive for admission to a DSH hospital undergo COVID-19 RNA testing and are housed when possible as a cohort in an Admission Observation Unit (AOU) where they are separated from the rest of the hospital. Fully vaccinated patients arriving to DSH for admission, returning from out-to-hospital/clinic or out-to-court can proceed to their regularly assigned units if asymptomatic and if without known exposure after undergoing antigen or PCR testing upon arrival. Unvaccinated patients are tested at day 1, 5, and 10. If all three tests are negative, the patient can be moved to be housed in a regular unit if asymptomatic. If any of the three tests returns positive the patient is immediately moved to an isolation unit and the cohort testing schedule resets to day 1. If the following sequential two tests are negative, the patient can then be moved to be housed in a regular unit. Isolation units house confirmed COVID-19 patients. While housed in an AOU, if the patient develops symptoms consistent with COVID-19 disease, they are immediately moved to a patient under investigation (PUI) room where the patient is isolated and undergoes testing. DSH Management of COVID-19 Patients and PUI contains detailed instructions on the what actions to take if a patient is suspected or is confirmed to have COVID-19.

Table 1. PPE Required in Admission Observation Units

| REQUIRED PPE | AVAILABLE UPON REQUEST |
|---|---|
| • Surgical Mask<br>• N-95 Respirator provided and strongly encouraged to be worn by unvaccinated and not fully vaccinated staff | • N-95 Respirator<br>• Face Shield<br>• Gloves<br>• Gown |

## Figure 1. COVID-19 Admission & Serial Testing



## II. Quarantine Testing

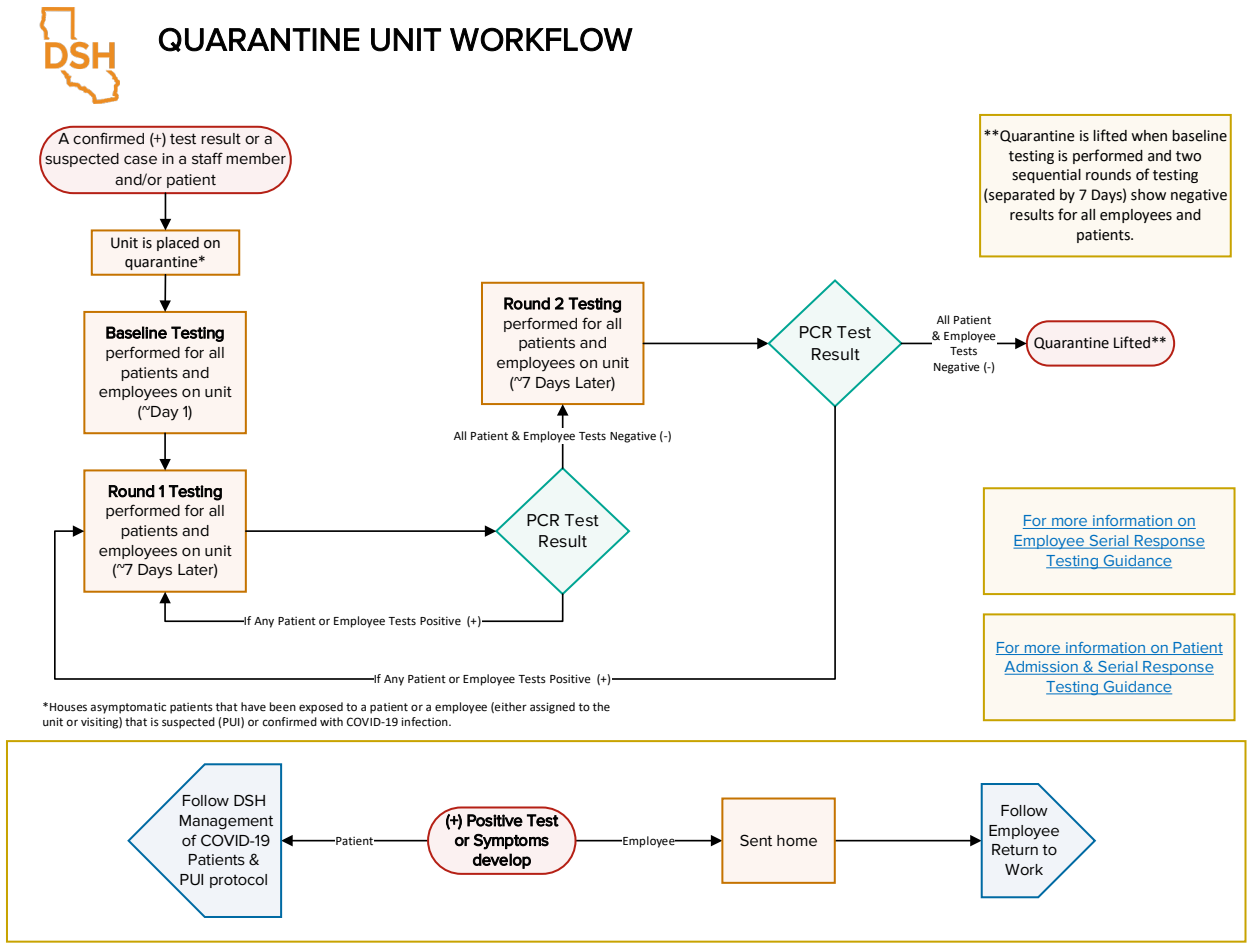
Quarantine units house patients that have been exposed to COVID-19 while receiving care in the hospital. A Quarantine Unit is activated when there is a confirmed or suspected COVID-19 patient and/or HCP. If a unit is quarantined due to contact with someone with suspected COVID-19 who is subsequently tested and receives a negative result, the unit can be released from quarantine and retesting should be considered. See Interim Guidance on Testing for SARS-CoV-2 in Correctional and Detention Facilities. All patients undergo serial response testing at baseline, day 7 and day 14. If all patients test negative for all three tests the quarantine status is discontinued. If a patient has a positive test result, the unit continues in quarantine which will be released when no new patient positive test results are found for 2 consecutive rounds of testing, separated by 7 days, and excluding baseline testing. Quarantine can be released based only on patient negative test results and the absence of any new onset of illnesses among patients and/or employees (HCPs).

Serial Response testing for staff (HCP), Hospital Police Officers (HPO) and Correctional Officers when applicable, is performed every seven days until there are no new positive test results for 2 consecutive rounds of testing excluding baseline testing.

Table 2. PPE Required in Quarantine Units

| REQUIRED PPE | AVAILABLE UPON REQUEST |
|---|---|
| • N-95 Respirator<br>• Face Shield<br>• Gloves | • Gown |

## Figure 2. Quarantine Unit Workflow



## III. Isolation Unit Testing

Isolation units house patients confirmed to have COVID-19 disease. All patients have had a positive test result. Patient's transmission-based precautions are discontinued using a symptom-based or time-base strategy.

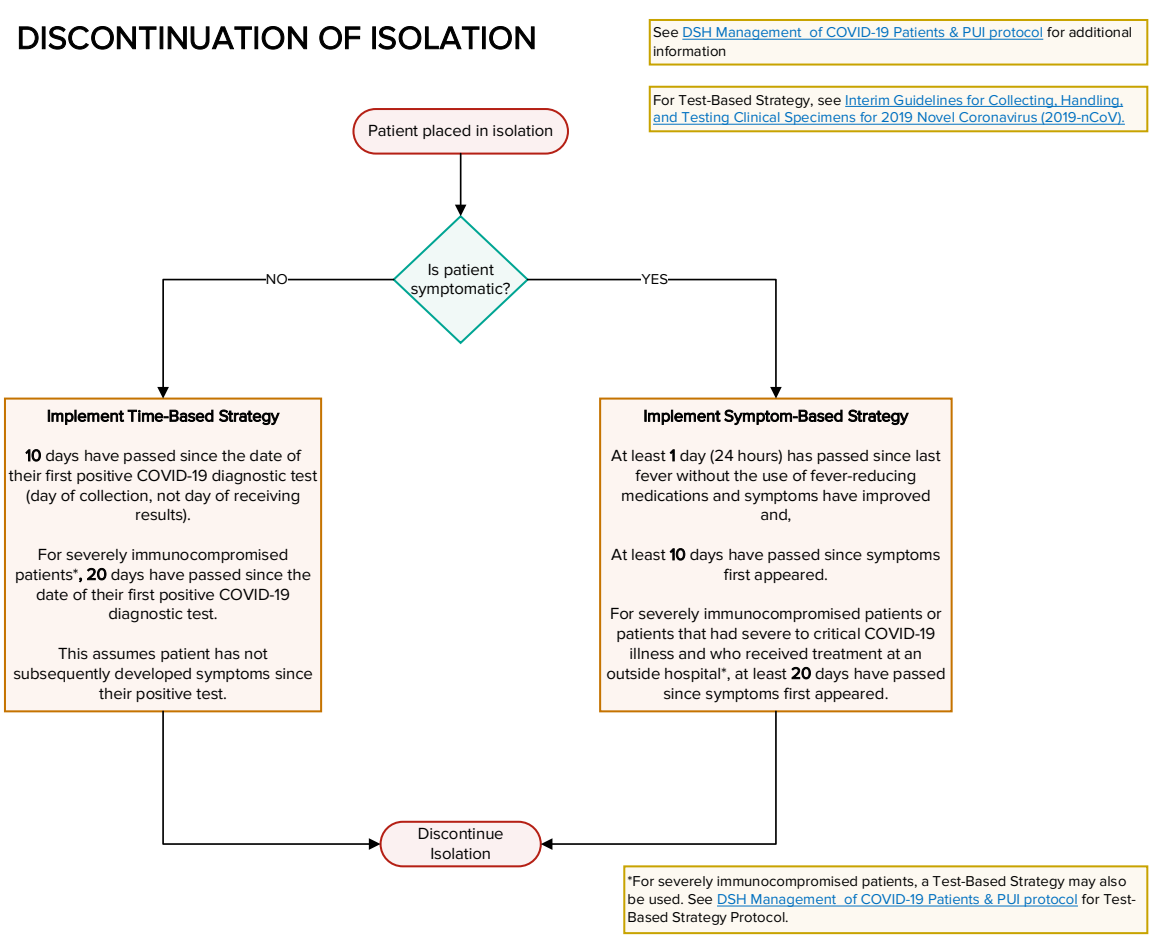
- *Symptom-based strategy:*
    - At least 1 day (24 hours) have passed *since last* fever without the use of fever-reducing medications, **and**
    - Symptoms consistent with COVID-19 disease (e.g. cough, shortness of breath, etc.) have improved, **and**
    - At least **10 days** have passed *since symptoms first appeared.*
        - ➢ *For severely immunocompromised patients or severely symptomatic patients, a time frame of **20 days** since symptoms first appeared is recommended after consultation with either the Chief Physician& Surgeon, the Medical Director or an ID specialist. In this situation a negative "Test-based Strategy" may also be used.*

- *Time-based strategy*.
    - **10 days** have passed since the date of their first positive COVID-19 diagnostic test, assuming they have not subsequently developed symptoms since their positive test.
        - ➢ *For severely immunocompromised patients, a time frame of **20 days** since the date of their first positive test is recommended after consultation with either the Chief Physician& Surgeon, the Medical Director or an ID specialist. In this situation a negative "Test-based Strategy" may also be used.*

Table 3. PPE Required in Isolation Units

| REQUIRED PPE | AVAILABLE UPON REQUEST |
|---|---|
| • N-95 Respirator<br>• Face Shield<br>• Gloves | • Gown |

## Figure 3. Discontinuation of Isolation



# IV. Diagnostic Screening Testing

The purpose of a diagnostic screening testing is to detect new cases, prevent exposure, and mitigate outbreaks. Congregate living has the potential for rapid and widespread transmission of COVID-19. A broader testing strategy is recommended to reduce the chance of a large outbreak when contact tracing is difficult to perform. This is especially relevant with COVID-19 since there is a high proportion of asymptomatic cases. DSH in consultation with the California COVID-19 Testing Task Force and the California Department of Public Health (CDPH), Healthcare Associated Infection Program, has adopted diagnostic screening testing. HCP testing is mandatory. If an HCP refuses to be tested, disciplinary action may be taken.

DSH performs diagnostic screening testing of HCP, regardless of vaccination status, who provide direct patient care or who work in patient care areas using the Abbott BinaxNOW Antigen Card. This also includes but is not limited to HCP providing transportation, environmental services, culinary/dietary services to the unit, Hospital Police Officers (HPO) and Correctional Officers (CO) that provide transportation and escort patients to outside community services. All DSH staff, regardless of vaccination status, working in non-patient care areas must be tested at least twice weekly with either PCR testing or antigen testing.

A. Diagnostic Screening Testing for Staff working Patient Care Areas:
    - Effective 08/02/2021 DSH will return to daily antigen testing of staff who provide direct patient care or who work in patient care areas, regardless of their vaccination status.
        - If a staff's antigen test result is presumptive positive for COVID-19 infection, the supervisor arranges for the staff to immediately leave the patient care area and the staff is tested by PCR. Employees will receive ATO for their entire shift on the day they are sent home due to positive screening
            - If the results are of the PCR test are positive, the supervisor instructs the staff to isolate in the community (fully-vaccinated HCP with positive test results and Ct values of greater than 33 may be asked to retest, see Section V. Fully Vaccinated Asymptomatic Patients and HCP). Employees will receive ATO for their entire shift on the day they are sent home due to positive screening.
            - The staff follows the Return-To-Work protocol included in this document and returns to work using a time-based or symptom-base strategy as discussed in Section VIII.

B. Diagnostic Screening Testing for Staff working in Non-Patient Care Areas:

- Effective 08/02/2021 DSH staff working in non-patient care areas must be tested at least twice weekly with either PCR testing or antigen testing, regardless of their vaccination status.
    - If a staff's antigen test result is presumptive positive for COVID-19 infection, the supervisor arranges for the staff to be immediately tested by PCR. Employees will receive ATO for their entire shift on the day they are sent home due to positive screening.
    - If the results are of a staff's PCR test are positive, the supervisor instructs the staff to isolate in the community (fully-vaccinated HCP with positive test results and Ct values of greater than 33 may be asked to retest, see Section V. Fully Vaccinated Asymptomatic Patients and HCP). Employees will receive ATO for their entire shift on the day they are sent home due to positive screening
    - The staff follows the Return-To-Work protocol included in this document and returns to work using a time-based or symptom-base strategy as discussed in Section VIII.

C. Skilled Nursing Facilities Surveillance/Screening Staff testing

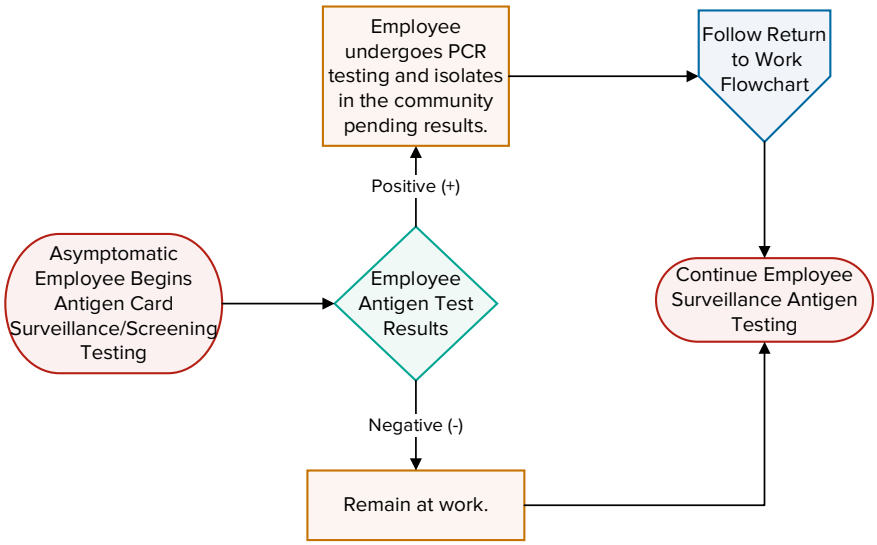
- DSH follows all CDPH AFLs for surveillance/screening testing in SNF units.
- SNF units follow DSH's Diagnostic Screening/Routine testing of staff as above.
- SNF units test, at a minimum, a random sample of 10% of all patients weekly, or as required by local public health department.

D. Testing for HCP recovered from COVID-19 Disease

- If the HCP has recovered from COVID-19 disease and remain asymptomatic throughout the 90 days from release of isolation, they do not participate in Diagnostic Screening or response testing during this period.
- If the HCP at any time have new onset of symptoms during the 90-day period, they follow isolation and testing in Section VII. Healthcare Personnel (HCP) Screening for positive symptoms.
- After the 90-day period, the HCP will resume current surveillance/ screening testing protocols.

Figure 4. COVID-19 Employee Daily Antigen Surveillance/Screening Testing

## COVID-19 EMPLOYEE DAILY ANTIGEN SURVEILLANCE / SCREENING TESTING



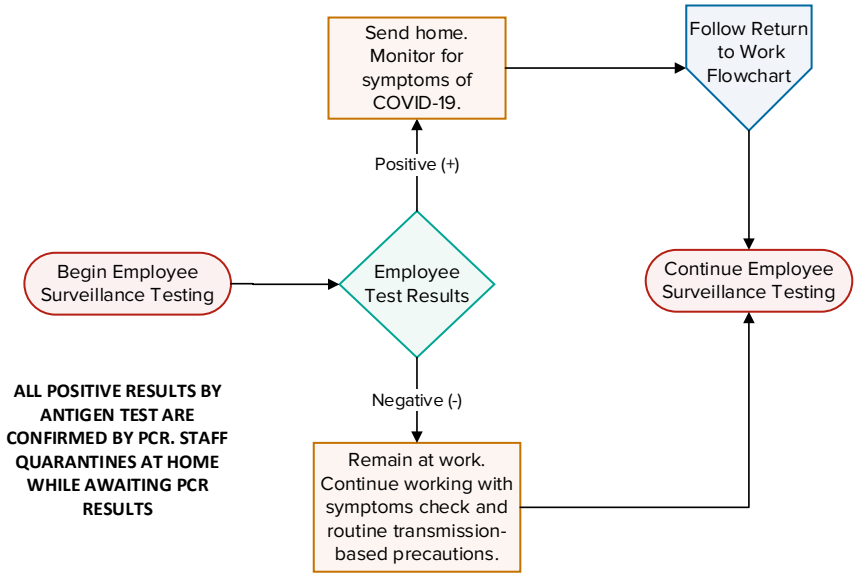

*For SNF units please see DSH SNF Testing and Surveillance

References:

- AFL-20-53 Corona Virus Disease 2019 (COVID-19) Mitigation Plan Recommendations for Testing of Health Care Personnel (HCP) and Residents at Skilled Nursing Facilities (SNF)
- California Department of Public Health (CDPH) Hospital Acquired Infections (HAI)Team consultation.

## Figure 5. COVID-19 Twice Weekly Employee Surveillance/Screening Testing

### COVID-19 TWICE WEEKLY EMPLOYEE SURVEILLANCE / SCREENING TESTING

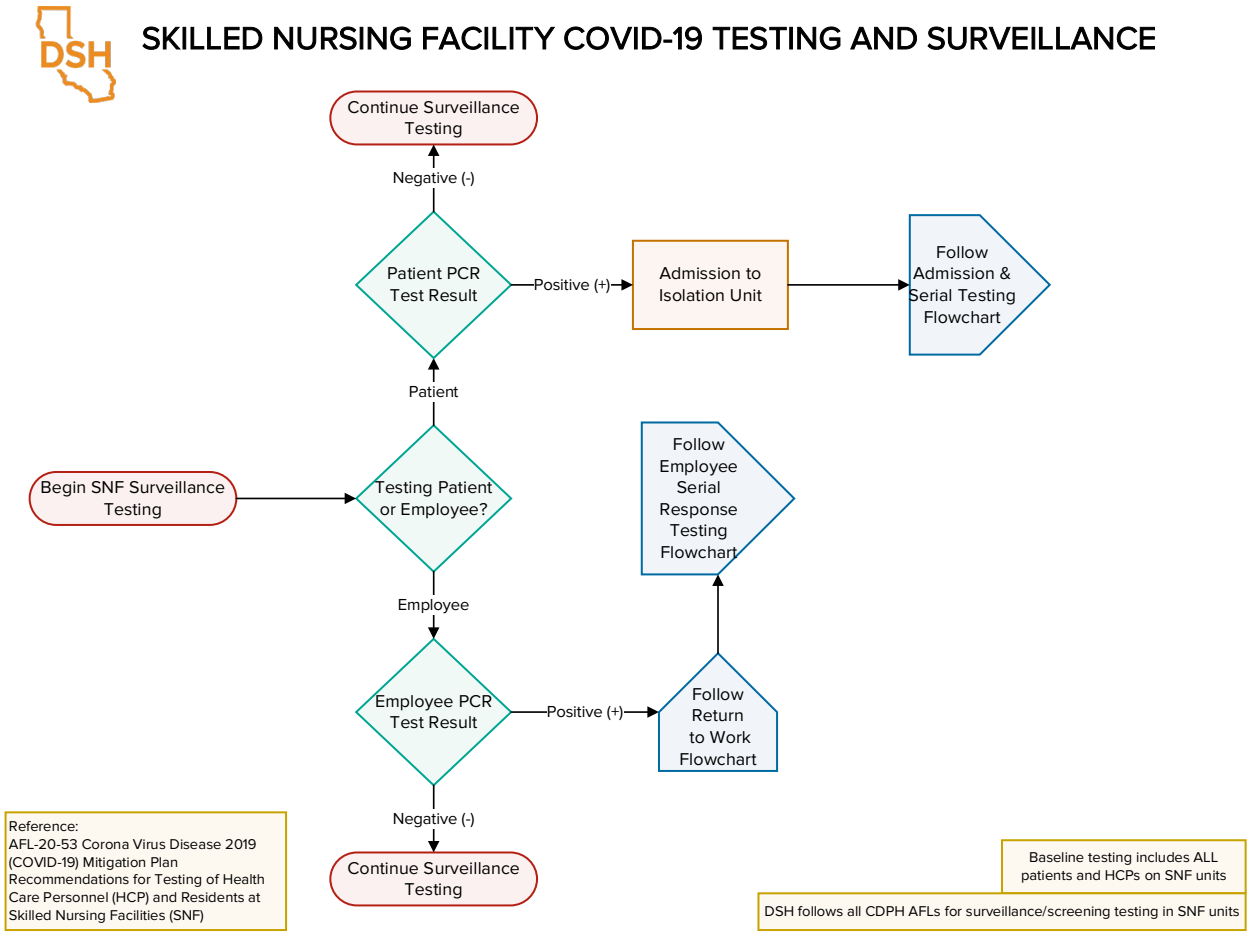



*For SNF units please see DSH SNF Testing and Surveillance

References:

- AFL-20-53 Corona Virus Disease 2019 (COVID-19) Mitigation Plan Recommendations for Testing of Health Care Personnel (HCP) and Residents at Skilled Nursing Facilities (SNF)
- California Department of Public Health (CDPH) Hospital Acquired Infections (HAI)Team consultation.

## Figure 6. Skilled Nursing Facility COVID-19 Testing and Surveillance



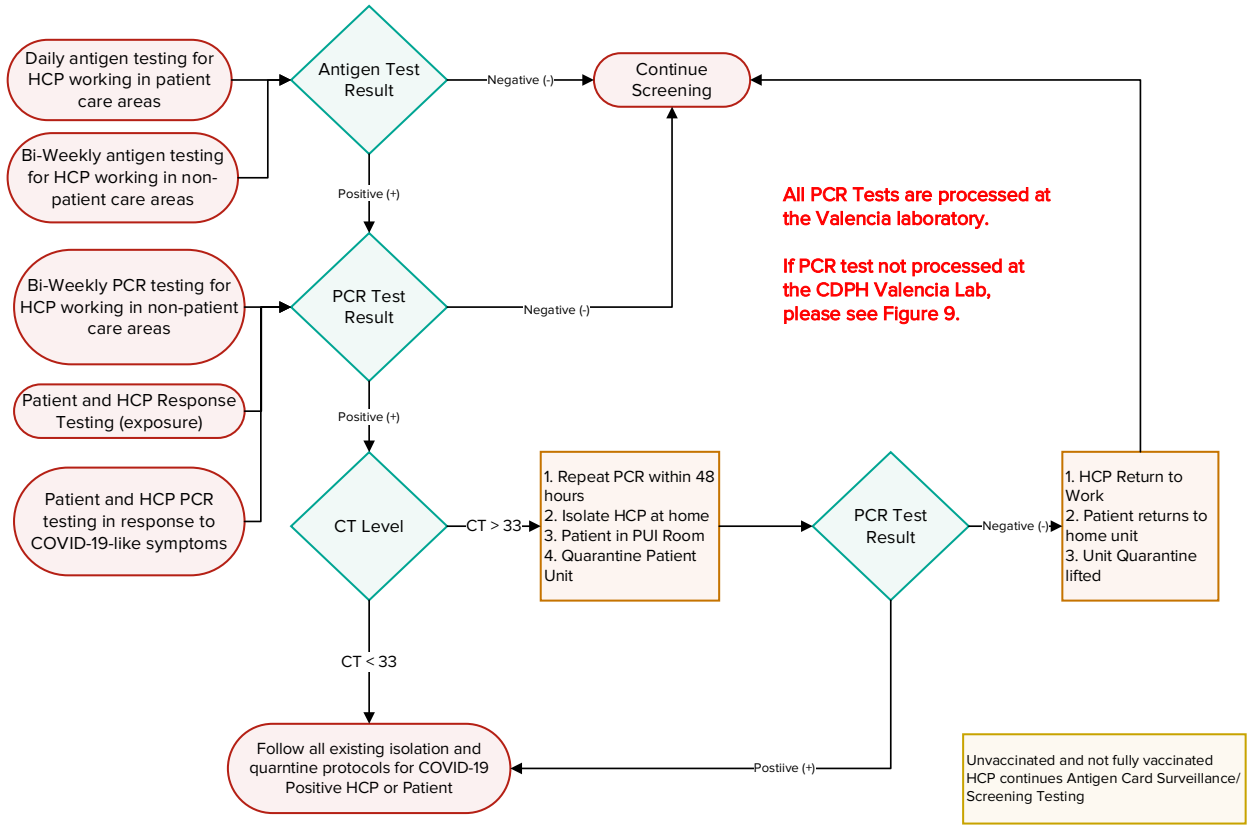
# V. COVID-19 Testing of Fully Vaccinated Patients and HCP

Fully vaccinated patients who are exposed or develop COVID-like symptoms are tested by PCR and placed in a PUI room until the results return and their home unit is quarantined. If the PCR result is negative, the patient is released from PUI and the home unit is released from quarantine. If the result is positive and the patient's PCR Ct value is less than or equal to 33, the patient is transferred to an isolation unit. The patient's home unit remains on quarantine and participates in serial testing. If the PCR Ct value is greater than 33, the PCR test is repeated within 48 hours. The patient remains in a PUI room awaiting the results of the second PCR and the home unit remains on quarantine. If the patient's second PCR result is negative, the patient is released from PUI and the home unit quarantine ends.

Fully vaccinated HCP who test positive during antigen screening testing or have COVID-like symptoms, are tested by PCR and quarantine at home while awaiting confirmatory PCR results. If the PCR test is negative, but symptoms remain, HCP may return to work if screening shows no fever in the last 24 hours (<100 degrees without fever reducing medications) with improving symptoms. Otherwise, the HCP may take his/her own sick time until symptoms improve per the guidance of their own primary care provider. If the PCR is positive and the HCP's PCR Ct value is less than or equal to 33 the HCP will remain off work for 10 days either from the positive test date or date of the onset of symptoms. If the PCR Ct value is greater than 33, the PCR test is repeated within 48 hours. The HCP remains at home to quarantine until the results of the second PCR. If the HCP second PCR result is negative the staff may return to work. If the second PCR test is positive, the HCP isolates at home for 10 days.

DSH uses the State of California Department of Public Health - Valencia Branch Laboratory to process PCR samples. The assay in this lab is more sensitive than other PCR assays that are used in community-based laboratories, for this reason a Ct value of 33 is recommended by CDPH as the cut off for clinically relevant cases.

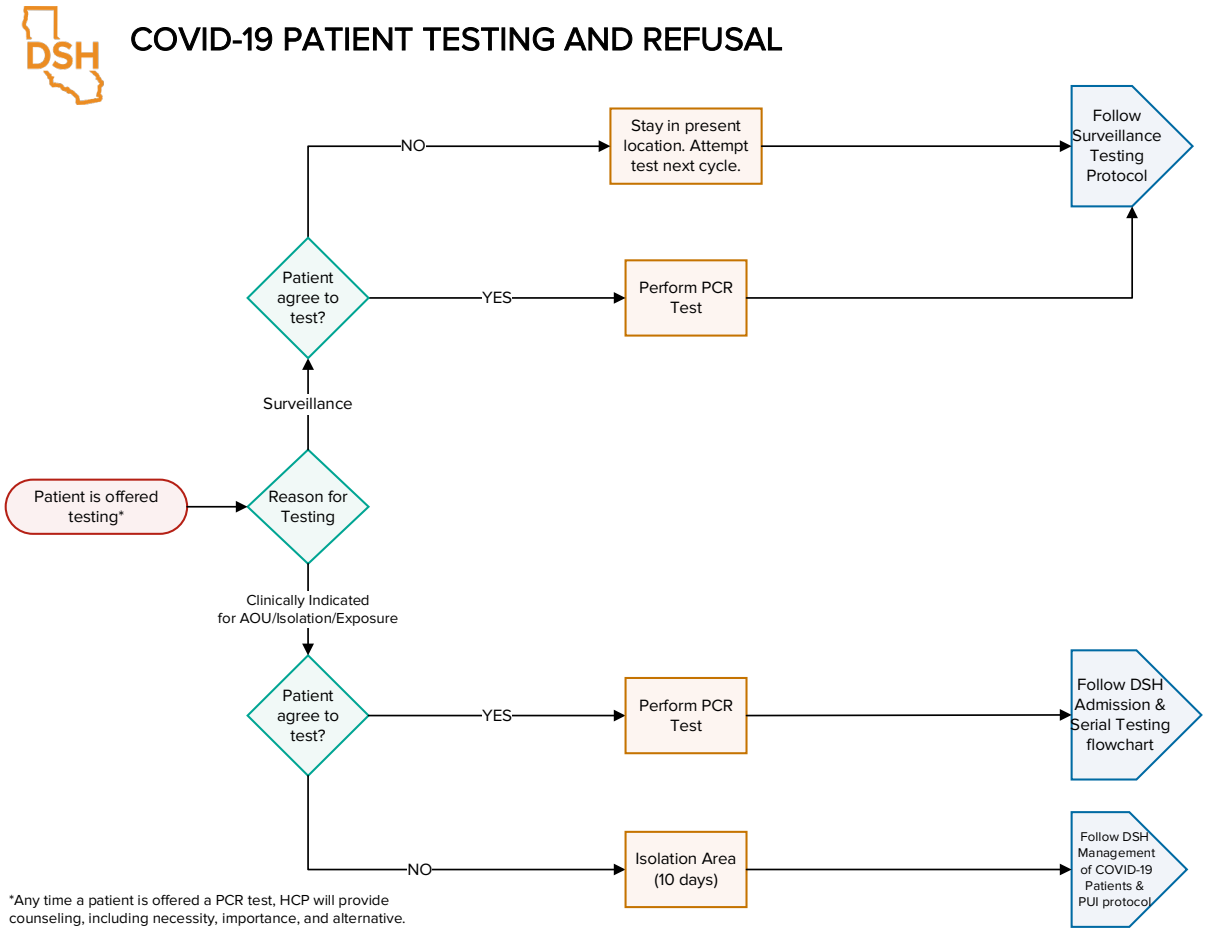
## Figure 7. Fully Vaccinated Patients and HCP COVID-19 Testing and Response



# VI. Patient Testing Refusal

If a patient refuses testing, the HCP provides education and members of the treatment team develop a plan to incentivize the patient to participate in testing. Surveillance testing is voluntary for patients. If, despite of all efforts, the patient refuses to test during the admission process, while in quarantine or for response testing, the patient is placed in an isolation area for 14 days. For patients that are refusing testing in AOU, Quarantine Units and in isolation, testing is offered at least daily and is performed as soon as the patient agrees to test.

## Figure 8. COVID-19 Patient Testing and Refusal



# VII. Healthcare Personnel (HCP) Screening

All HCP undergoes COVID-19 screening prior to entering the care areas of the hospital. DSH HCP screening process consist of a primary screening and a secondary screening. Prior to entering the hospital, the primary screener takes the HCP's temperature and asks if in the last 14 days the HCP member has been in contact with an individual who has been diagnosed with COVID-19 and if the HCP is experiencing the flowing symptoms:

- Fever or chills
- Cough, dry or productive
- Dyspnea or difficulty breathing
- Fatigue
- Myalgia/muscle aches or body aches
- Headaches
- New loss of taste or smell
- Sore throat
- Nasal congestion or runny nose
- Nausea, vomiting and diarrhea

If the temperature of the HCP is equal or greater to 100°F or answered "Yes" to any of questions, the HCP undergoes secondary screening.

The secondary screening is performed by a RN. During the secondary screening process the HCP's temperature is taken again and more detailed questions are asked to determine if the HCP should be sent home or can proceed to enter the hospital and report to their assigned workspace.

During the secondary screening process, the RN confirms the symptoms and determines if the HCP had a prolonged close exposure to an individual with COVID-19 disease. The RN completes the DSH Secondary Screening Healthcare Personnel (HCP) Questionnaire. At the end of each shift all questionnaires are returned to the Public Health Office.

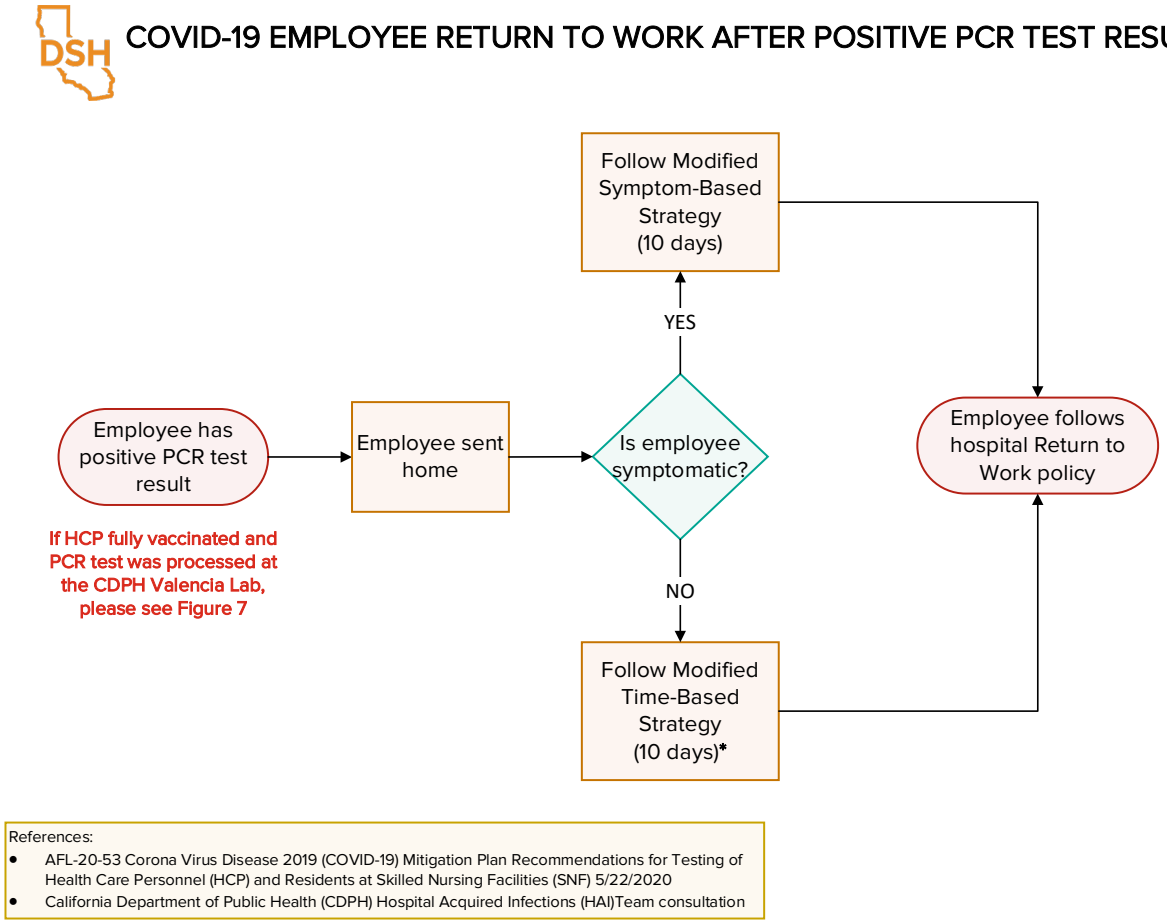
If an HCP is sent home, the RN provides to the HCP member DSH COVID-19 Positive Risk Screening Instruction Form. This form contains instructions on what are the steps for the HCP to take from home.

All HCP screeners, primary and secondary, undergo surveillance testing monthly.

# VIII. Return to Work

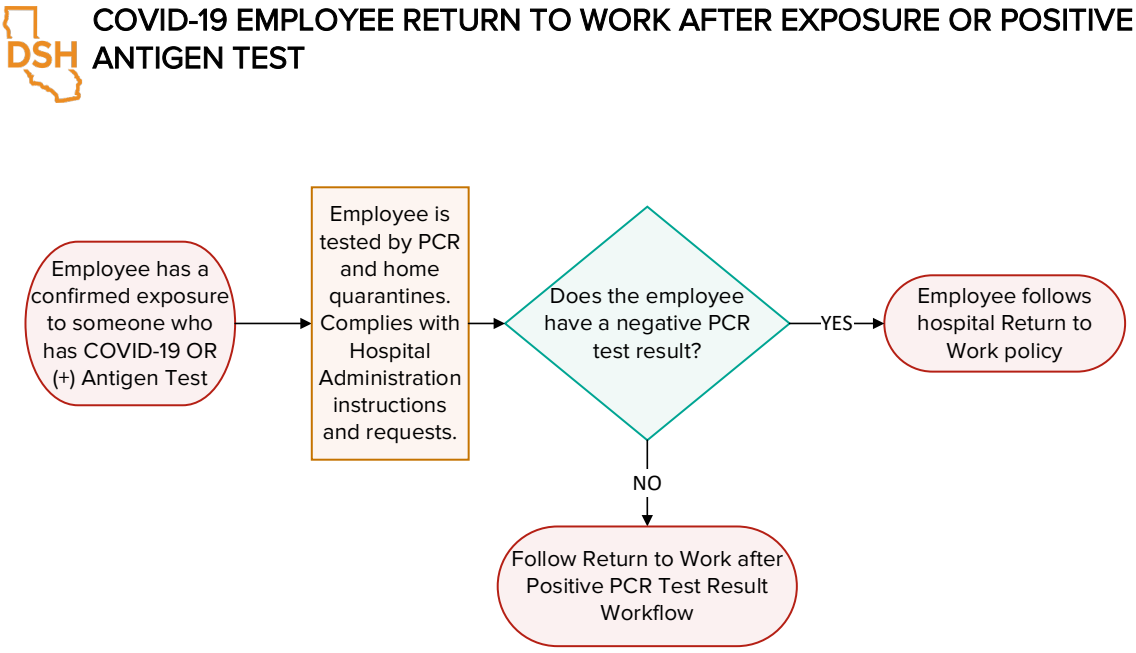
If an HCP tests positive for COVID-19 by PCR, they are sent home to follow a symptom-based or time-based strategy to return to work as recommended by the CDC. If an HCP develops symptoms consistent with COVID-19 disease, they follow a symptom-based strategy for return to work. If the HCP does not develop symptoms consistent with COVID-19, they follow a time-based strategy to return to work.

## Figure 9. COVID-19 Employee Return to Work




Unvaccinated staff confirmed to have an exposure to someone with COVID-19 are excluded from work. Fully vaccinated, asymptomatic HCP are not required to quarantine after an exposure. Fully vaccinated HCP who are exposed monitor for developing symptoms consistent with COVID-19 disease. If symptoms develop, the HCP quarantines at home and follows DSH testing and return to work protocols.

## Figure 10. COVID-19 Employee Return to Work After Exposure or Positive Antigen Test




References:

- AFL-20-53 Corona Virus Disease 2019 (COVID-19) Mitigation Plan Recommendations for Testing of Health Care Personnel (HCP) and Residents at Skilled Nursing Facilities (SNF) 5/22/2020
- California Department of Public Health (CDPH) Hospital Acquired Infections (HAI)Team consultation

# IX. Travel Guidance for HCP

DSH follows CDC guidelines for domestic (within the US and territories) and international travel.

Table 5. Domestic and International Travel Guidance for HCP

| DOMESTIC TRAVEL | UNVACCINATED/ NOT FULLY VACCINATED | FULLY VACCINATED |
|---|---|---|
| Get tested 1-3 days before traveling | X | |
| Get tested 3-5 days after traveling | X | |
| Quarantine for 7 days if tested or 10 days if not tested | X | |
| Self-monitor symptoms | X | X |
| Wear mask and take other precautions during travel | X | X |
| **INTERNATIONAL TRAVEL** | **UNVACCINATED/ NOT FULLY VACCINATED** | **FULLY VACCINATED** |
| Get tested 1-3 days before traveling | X | |
| Get tested 3-5 days after traveling | X | X |
| Quarantine for 7 days if tested or 10 days if not tested | X | |
| Self-monitor symptoms | X | X |
| Wear mask and take other precautions during travel | X | X |

# X. Visitation During Re-Opening

In-person visitation may be modified or suspended based on the hospital's current COVID-19 conditions or as recommended by CDC, CDPH and local Public Health Department guidance.

Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. Staff should provide monitoring for those who may have difficulty adhering to core principles, such as children.

Infection prevention measures are performed by hospital staff before and after each visit.

Visitors are screened for COVID-19 signs and symptoms and close contact with individuals with COVID-19 in the prior 14 days. Visitors will have their temperature taken.

Visitors who are screened out will be asked to leave the hospital immediately and reschedule the in person visit or will be provided with an opportunity to schedule a video visit.

Facilities may limit the number of visits per patient and limit the number of visitors in the facility at one time.

Video visitations will continue during reopening.

Risks associated with visitation shall be explained to patients and visitors.

All visitors are required to provide proof of vaccination or a negative COVID-19 test (PCR or Antigen collected within 72 hours of the visit) at the time of the scheduled visitation to be allowed to participate in an in-person visit. Hospitals reserve the right to deny visitation based on infection prevention measures not included in these guidelines.

CDPH Guidance for Vaccine Records Guidelines & Standards states that only the following modes may be used as proof of vaccination:
1. COVID-19 Vaccination Record Card (issued by the Department of Health and Human Services Centers for Disease Control & Prevention or WHO Yellow Card) which includes name of person vaccinated, type of vaccine provided, and date last dose administered); OR
2. a photo of a Vaccination Record Card as a separate document; OR
3. a photo of the client's Vaccination Record Card stored on a phone or electronic device; OR
4. documentation of COVID-19 vaccination from a health care provider; OR
5. digital record that includes a QR code that when scanned by a SMART Health Card reader displays to the reader client name, date of birth, vaccine dates and vaccine type. The QR code must also confirm the vaccine record as an official record of the state of California, OR

6. documentation of vaccination from other contracted employers who follow these vaccination records guidelines and standards.
In the absence of knowledge to the contrary, a facility may accept the documentation presented as valid.

Antigen Testing of visitors age 4 or older will be offered at the time of the visit for in-person visitation if negative PCR, negative antigen test results or if proof of vaccination is not provided. Visitors without proof of vaccination or negative COVID-19 test will not be allowed to visit.

We strongly encourage all visitors to be vaccinated, but we do not provide vaccine for visitors.

Vaccinated and unvaccinated patients with active COVID-19 disease or in quarantine are not permitted to have visitors until release criteria from isolation or quarantine are met.

Admission Observation Units are not permitted to have in-person visits.

Facilities should consider scheduling visits for a specified length of time to help ensure as many patients as possible are able to receive visitors. Visits should be scheduled for no less than 30 minutes. Longer visits should be supported.

No food or drink is allowed during visitation.

Facilities shall have a plan to manage visitations and visitor flow with clear directions posted for all visitors.

Hand hygiene should be performed by both parties before and after the visit and source control (masks) be worn regardless of the COVID-19 vaccination status.

All visitors, regardless of their vaccination status, must wear a well-fitting face mask and perform hand hygiene upon entry and in all common areas in the facility.

Visitors and patients must wear masks for source control during visitation. The only exception is children under the age of 2. Surgical masks will be provided and required to be worn by visitors at the hospital.

Visitors and patients maintain 6-feet distance during the visit.

Visitors shall maintain distance from other visitors, patients, and staff.

All other facility policies related to visiting regulations, attire, and allowable items remain in effect.

See Section XI. Guidelines for Patient Activities During Re-Opening for additional information.

# XI. Guidelines for Patient Activities During Re-Opening

Guidelines are based on recommendations by the CDPH and public health departments where the hospital is located. All off-unit activities should be conducted with source control (cloth covering/masks) and maintaining 6-feet of distance at all tiers. **Hospitals may be more restrictive based on the their current COVID-19 conditions or as recommended by CDC, CDPH and local Health Departments guidance.**

These guidelines for opening activities and services in DSH have been developed with the intent to provide the hospitals a thoughtful and safe road map to full operations by August 16, 2021. More rapid progression to Phase 3 is allowed if resources and safety permits. Each Hospital's Executive Team can modify this plan to account for local conditions and transmission patterns or based on guidance by the local Health Department.

Table 6. Guideline for Patient Activities During Re-Opening

| PHASE 1 | BEGINNING JUNE 16, 2021 |
|---|---|
| Off Unit<br>Courtyard<br>Meals<br>Groups<br>Religious services<br>Patient workers | Up to 45% of total hospital units |
| Barbershop/Beauty Salon | Individual at the site or on the unit |
| Patient Gym/Sports | Up to 50% capacity |
| Visitation | In-person visitation in the visitation area is available for fully, partially, or non-vaccinated patients. Testing for unvaccinated and partially vaccinated patients before and after the visit is recommended. |
| **PHASE 2** | **BEGINNING JULY 16, 2021** |
| Off Unit<br>Courtyard<br>Meals<br>Groups<br>Religious services<br>Patient workers | Up to 75% of total hospital units |
| Barbershop/Beauty Salon | Individual at the site or on the unit |
| Patient Gym/Sports | Up to 50%-75% capacity |

| | |
|---|---|
| Visitation | In-person visitation in the visitation area is available for fully, partially, or non-vaccinated patients. Testing for unvaccinated and partially vaccinated patients before and after the visit is recommended. |
| **PHASE 3** | **TO BE DETERMINED** |
| | Hospital at full operations |

# XII. Influenza During the Pandemic and the COVID-19 Rapid Antigen Test

This guidance is developed based on CDC recommendations to address the combined risk faced by patients and staff during the upcoming flu season and ongoing COVID-19 pandemic. While more is learned daily, there is still a lot that is unknown about COVID-19 disease and the virus that causes it. CDC recommendations and this Guidance may change in the future as more information about COVID-19 becomes available.

Please refer to the **DSH CLINICAL GUIDANCE INFLUENZA PREVENTION AND CONTROL DURING THE COVID-19 PANDEMIC** for more detail information.

The following recommendations are also applicable to other respiratory infections besides COVID-19 and Flu such as Respiratory Syncytial Virus (RSV), Strep Throat and others.

Influenza (Flu) and COVID-19 are contagious respiratory illnesses caused by different viruses. COVID-19 is caused by infection with a new coronavirus (SARS-CoV-2) and flu is caused by infection with influenza viruses.

It is possible to be infected with the flu, as well as other respiratory illnesses and COVID-19 at the same time. Health experts are studying how common this can be. Flu and COVID-19 share many characteristics including similar symptoms; it may be hard to tell the difference between both infections based on symptoms alone, and **TESTING MAY BE NEEDED TO HELP CONFIRM A DIAGNOSIS.** Diagnostic testing can help Health Care Providers (HCP) to determine if a patient is sick with flu or similar respiratory infections, and/or COVID-19. More information about clinical similarities and the differences between Flu and COVID-19 are provided in the following Weblinks:

https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htm#

https://www.cdc.gov/flu/symptoms/testing.htm

Utilize the laboratories available in your hospital to perform the necessary COVID-19, Influenza A/B and Respiratory Syncytial Virus (RSV) tests in compliance with CDC guidance.

**Patients who present with symptoms consistent with COVID-19 disease and other respiratory infections require isolation until COVID-19 diagnostic testing is performed and COVID-19 is confirmed or ruled out.** Patient can be infected with COVID-19 and other respiratory viruses such as Influenza and RSV at the same time.

California Department of Public Health (CDPH) recommends that congregate living setting develop plans to quickly diagnosis, isolate and treat Influenza considering the current SARs CoV2 Pandemic. In high risk setting as in the DSH-Hospitals, once influenza

is circulating in the community, it will be important to rapidly test for both flu and SARS-CoV-2 whenever anyone presents with respiratory tract signs and probably G.I. tract symptoms/signs.

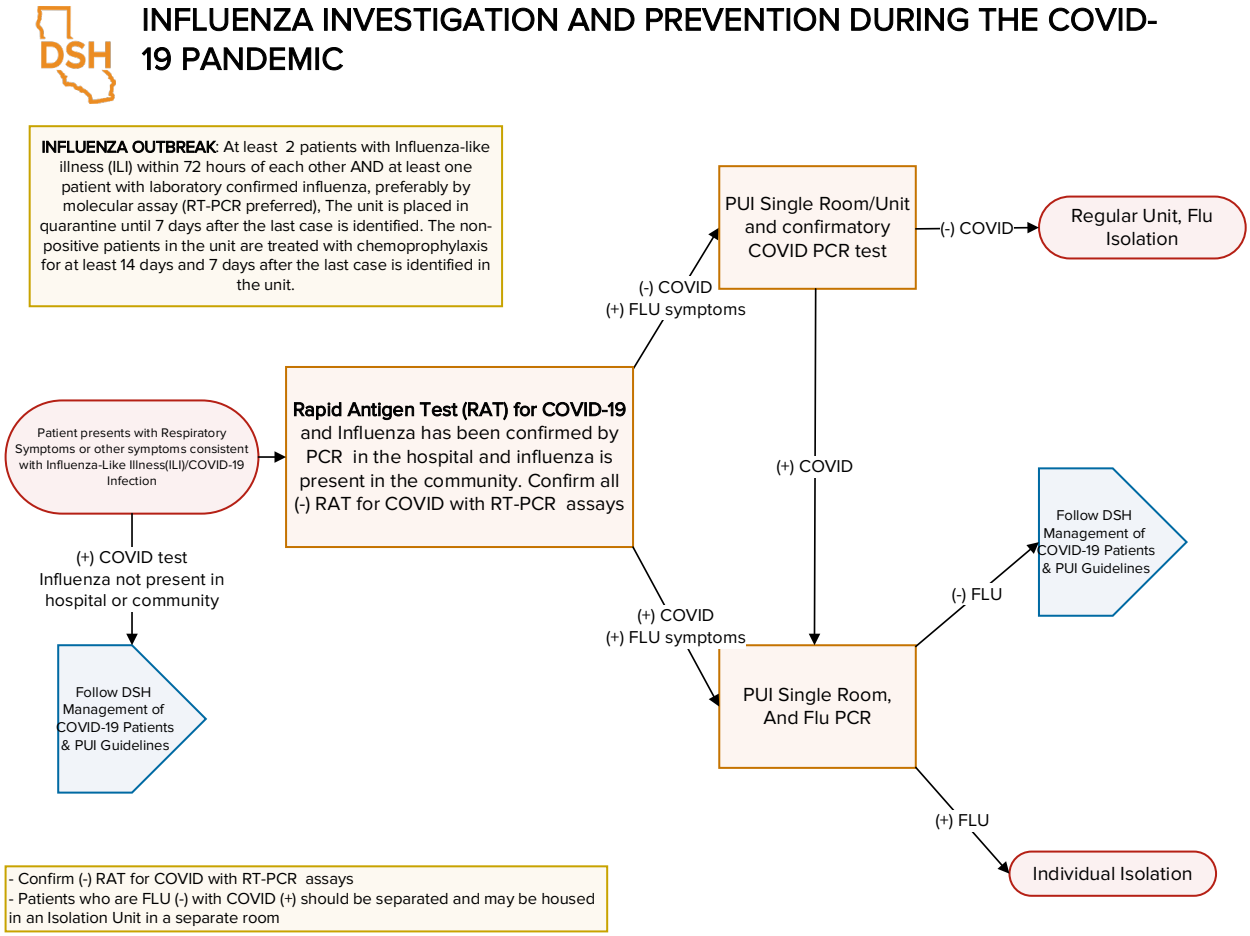
The symptoms of influenza and Covid-19 overlap. An individual infected with either Influenza viruses or SARS CoV2 virus can present with fever, cough, sore throat, runny or stuffy nose, body aches, headache, chills and/or fatigue. Viral assays are important to aid the diagnostic process because it is very difficult to determine the source of the infection by only clinical symptoms.

Infections with Influenza and SARS- CoV2 are important to diagnose quickly because:

1) Both infectious diseases can spread rapidly in congregate living settings,
2) The decision to isolate a patient with both Covid-19 and Influenza is very important and patients with one illness should not be isolated in the same location as patients with the other illness.
3) Patients co-infected with Influenza (A or B) virus AND SARSCoV2 should be isolated separate from patient infected with either SARS CoV2 virus OR Influenza virus to decrease risk of co infection to the whole population.
4) A co-infection with both Covid-19 and Influenza viruses leads to 5.92 times the mortality than in a patient without either viral infection.
5) Influenza A and B viral infections have several pharmacological treatment options, all of which work best if initiated within 48 hours of diagnosis.
6) While there is no definitive prophylaxis to prevent Covid-19 infection, the CDC recommends chemoprophylaxis for any patient who has contact with an individual known to have been infected with Influenza regardless of Influenza vaccination status.
7) While Influenza viral testing is not required to make a clinical diagnosis of Influenza in the setting of an Influenza outbreak, the distinction between Influenza and SARS- CoV2 in the time of a Corona virus pandemic is critical.
8) Multiple commercial molecular assays are available for the diagnosis of both Influenza and SARS-Cov2, and the faster a positive test can be returned, the faster the response to an outbreak in a high-risk clinical setting.
9) Rapid antigen tests can return results in a fast as 15 minutes and can be done at the point of care, while Rt-PCR assays require a CLIA approved laboratory and typically return in 24-48 hours (if available test reagents and lab support are available). A 24-48 hours TAT cannot be guaranteed specially during time of increasing wide spread of C-19 or influenza and increasing the demands for testing and reporting of results.
10) The use of a rapid antigen testing for both Influenza and SARS CoV2 is not meant to replace the use of RT-PCR as gold standard diagnosis of SARs-CoV2 but can

be additive in the clinical decision tree of diagnosis and treatment. All negative rapid antigen tests should be confirmed by RT-PCR test results.

Figure 11. Influenza Investigation and Prevention During the COVID-19 Pandemic



## XIII. COVID-19 Units/Processes and Personal Protective Equipment (PPE) Summary

Table 7. COVID-19 Units/Processes and Personal Protective Equipment (PPE) Summary

| UNIT TYPE or PROCESS | REQUIRED PPE | AVAILABLE UPON REQUEST |
|---|---|---|
| **Isolation Unit:** | • N-95 Respirator<br>• Face Shield (when providing direct patient care)<br>• Gloves (when providing direct patient care) | • Gown |
| **PUI Room(s)** | • N-95 Respirator provided and strongly encouraged to be worn by unvaccinated and not fully vaccinated staff. Face Mask inside nursing station and break room.<br>• N-95 Respirator (when providing direct patient care)<br>• Face Shield (when providing direct patient care)<br>• Gloves (when providing direct patient care) | • Gown |

| UNIT TYPE or PROCESS | REQUIRED PPE | AVAILABLE UPON REQUEST |
|---|---|---|
| Admissions Observation Unit | • N-95 Respirator provided and strongly encouraged to be worn by unvaccinated and not fully vaccinated staff. Face Mask inside nursing station and break room.<br>• N-95 Respirator (when providing direct patient care)<br>• Face Shield (when providing direct patient care)<br>• Gloves (when providing direct patient care) | • Gown |
| Quarantine Unit | • N-95 Respirator provided and strongly encouraged to be worn by unvaccinated and not fully vaccinated staff. Face Mask inside nursing station and break room.<br>• N-95 Respirator (when providing direct patient care)<br>• Face Shield (when providing direct patient care)<br>• Gloves (when providing direct patient care) | • Gown |

| UNIT TYPE or PROCESS | REQUIRED PPE | AVAILABLE UPON REQUEST |
|---|---|---|
| **Regular Unit:**<br>Unit that has not been placed on quarantine and does not have patients being treated, under investigation, or being observed for COVID-19. | • Surgical Mask<br>• N-95 Respirator provided and strongly encouraged to be worn by unvaccinated and not fully vaccinated staff | • Face Shield<br>• Gloves |
| **HCP Screening Process** | • Surgical Mask<br>• N-95 Respirator provided and strongly encouraged to be worn by unvaccinated and not fully vaccinated staff<br>• Face Shield<br>• Gloves | • N-95<br>• Gown |
| **CPR/ACLS** | • N-95 Respirator<br>• Face Shield<br>• Gloves<br>• Gown | |
| **High Risk Procedures:** COVID testing, blood draw | • N-95 Respirator<br>• Face Shield<br>• Gloves<br>• Gown | |
| **Transportation Staff:**<br>Any staff assigned to transport or escort a COVID+ patient or PUI in a vehicle (Example: To OMF appointments or on bus between compounds). | • N-95 Respirator<br>• Face Shield<br>• Gloves | |

| UNIT TYPE or PROCESS | REQUIRED PPE | AVAILABLE UPON REQUEST |
|---|---|---|
| **Administrative or Non-Treatment Areas Located Outside the STA With No Patient Contact:**<br>Staff or visitors to offices and departments on grounds but outside secured treatment area. | • Surgical mask<br>• N-95 Respirator provided and strongly encouraged to be worn by unvaccinated and not fully vaccinated staff | |